Riveroaks Estate
9475 Petit Road
Baker, LA 70714

Date - 05/10/2005
License # - 10513
Action Code - 5

Statement of Deficiencies

8815-B,C: Governing Body **Not Met**

Findings/Corrections

8815 C. 10. The governing body of the Provider failed to inform designated representatives of DSS prior to initiating any substantial changes in the services provided by the Provider. Provider has a new Director and the Governing body did not notify DSS of the change.

8815-D: Jurisdictional Approvals **Not Met**

Findings/Corrections

8815 D. 2. The Provider failed to secure an Office of Public Health approval. Health inspected facility on 3/31/05 and left violations.

8817-I: Personnel Files **Not Met**

Findings/Corrections

8817 I. 1. (d,) The Provider failed to maintain a personnel record for each employee identified below that included:
d. documentation of TB test results and any other provider required medical examinations,

8821-E: Resident Funds **Not Met**

Findings/Corrections

8821 E. 2. a. The Provider failed to obtain written authorization from the resident and/or his/her representative to safekeeping of funds. Providers parent corporation Options Foundation is the payee of clients Social Security. Options keeps clients money and pays expenses out of this money. Options gives some of the money to Riveroaks for client to use.
8821 E. 2. b. The Provider failed to provide each resident with a receipt listing the amount of money the facility was holding in trust for the resident. Provider has 2 sets of client funds books. One is the money Options receives for management and one is RiverOaks money for the residents to spend.
8821 E. 2. d. The Provider accepted more than $200 of a resident's money. Some of the Options accounts have over $200.00 dollars in them. One client has $8000.00+ and One client has over $13,000.00.
8821 E. 3. a. The Provider failed to receive written authorization to manage the resident's funds from the resident. Provider has letter from Social Security naming them as Clients Payee.
8821 E. 3. c. The Provider failed to keep funds received from the resident for management in an individual account in the name of the resident. Provider has ledger for each client, but not separate accounts.

8821-G: Critical Incidents **Not Met**

Findings/Corrections

8821 G. 3. b. The Provider failed to immediately notify Department of Health and Hospitals Adult Protection Services or Office of Elderly Affairs in the Office of the Governor, the Bureau of Licensing, and other appropriate authorities, according to state law, with written notification to the above agencies to follow within 24 hours of the suspected incident which resulted in death of a resident, involved abuse or neglect of a resident, or entailed a serious threat to the resident's health, safety or well-being. Accident reports document 2 incidents where medication was not given correctly. One incident client received his PM medication instead of his AM medication and one client received another clients medication by mistake.
8821 G. 3. e. The Provider failed to provide follow-up written reports to all the persons and agencies listed in 8821.G.3.a.-d. of an incident which resulted in death of a resident, involved abuse or neglect of a resident, or entailed a serious threat to the resident's health, safety or well-being.
8821 G. 3. f. The Provider failed to take appropriate corrective action to prevent future incidents which result in death of a resident, involve abuse or neglect of a resident, or entail a serious threat to the resident's health, safety or well-being.
8821 G. 3. g. The Provider failed to document its compliance with all of the procedures of 8821.G.3.a.-f. for each incident, and failed to keep such documentation (including any written reports or notification) in the resident's file for incidents which resulted in death of a resident, involved abuse or neglect of a resident, or entailed a serious threat to the resident's health, safety or well-being with a separate copy of all such documentation kept in the provider's administrative file.

Statement of Deficiencies

8827-C,D: Medications and Health Related Services **Not Met**

Findings/Corrections

8827 C. 1. The Provider failed to have clear written policies and procedures on medication assistance.

8827 C. 7. An employee that provided assistance with the self-administration of medications to a resident failed to have documented training on the policies and procedures for medication assistance including the limitations of this assistance. Documentation failed to include the signature of the employee. Training on the policies and procedures for medication assistance including the limitations of assistance failed to be provided annually to employees providing assistance with the self administration of medications.

8827 C. 8. a. Residents who did not require assistance with self-administration of medications failed to be allowed to keep prescription and non-prescription medication in their living unit/bedroom. Medication failed to be kept secured from other residents.

8827 C. 8. b. ii. Medications kept in a secure central area failed to be delivered to the individual resident who required assistance with self-administration of medication at the appropriate time. Residents were required to come to a "medication" area to receive medications.